PRINTED: 08/05/2010 DEPARTMENT OF HEALTH AND H' 'AN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC, JD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 445160 08/02/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE MAYFIELD REHABILITATION CENTER **SMYRNA, TN 37167** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 038 NFPA 101 LIFE SAFETY CODE STANDARD K 038 It is the intent of this facility SS#D that exit access is arranged so Exit access is arranged so that exits are readily that exits are readily accessible accessible at all times in accordance with section 7.1. 19.2.1 at all times in accordance with section 7.1 1921 1. The decorator design on the exit door on 200 hall was This STANDARD is not met as evidenced by: removed. 8/2/10 Based on observation, it was determined the 2. Maintenance Supervisor facility failed to maintain the exits. and Assistant conducted a facility-wide audit of all the The findings included: exit doors to assure all exit Observation of the 200 hall exit on 8/2/10 at 9:50 doors were readily accessible. 8/2/10 AM, revealed the door window was cover up with 3. Maintenance department, a decorated design. National Fire Protection which consists of the Association (NFPA), 101, 7.5.1.1 Supervisor and Assistant. will begin a monthly audit This finding was acknowledge by the Administrator and verified by the Director of of the accessibility of all exit Maintenance at the exit conference on 8/2/10. doors as part of their pre-K 051: NFPA 101 LIFE SAFETY CODE STANDARD ventive maintenance pro-SS=F 9/13/10 A fire alarm system with approved components, Department Managers are devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide assigned routine compliance effective warning of fire in any part of the building. rounds during the weekdays Activation of the complete fire alarm system is by and assessing for accessibility manual fire alarm initiation, automatic detection or of exit doors will be included extinguishing system operation. Pull stations in 9/8/10 patient sleeping areas may be omitted provided in the rounds. that manual pull stations are within 200 feet of Department Managers will be nurse's stations. Pull stations are located in the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and

path of egress. Electronic or written records of

tests are available. A reliable second source of

administrator

inserviced by the Maintenance

Supervisor and Administrator

for including the monitoring of

exit doors.

Facility ID: TN7503

(X6) DATE 8/18/10

9/7/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | X3) DATE SURVEY COMPLETED | |
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| | K 038 | 3, cont'd | | Department Managers cons Asst. Director of Nurses, R Manager, MDS Nurses (2), Workers (2), Restorative N Activity Director and Assis Care Plan Nurse, Staff Dev ment Nurse, RN, Housekee Supervisor, Dietary Manag Treatment LPN, Maintenan Supervisor, Director of Nur Bookkeeper, Rehab Director Administrator. Findings of the compliance will be submitted to the discresponsible for correction. manager is responsible for a corrective action and for the documentation to the origin compliance rounds report we resolved. Compliance Round findings discussed during our weekd Morning Meeting with the ment Managers. 4. The Maintenance Supervisor measure the effectiveness of compliance with keeping all doors accessible through the monthly preventive maintener program. The program will a monthly audit of all exit of compliance. The Maintenance Supervisor The M | isk Social Jurse, Stant, Jelop- Jeping Jer, Jor and Tounds Jerine The Jer any Jer al Johen Jor will Jor the Jer and Je | 9/8/10 | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1` ` | ULTIPLE CONSTRUCTION LDING | (X3) DATE : COMPL | (X3) DATE SURVEY COMPLETED | |
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| | K 03 | 8, cont'd | | | his monthly of the CQI/QA mmittee con- urses, a 3 other mem- ff. ervisor is a this com- responsible by report will ol/QA & A clude audit sary action liewed by the tee with ecessary. The that any ided at each tee meeting ance is sommittee as been | 8/26/10 | |
| | | | } | | | 1 J | |

| | F OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | PLE CONSTRUCTION G 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | |
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| | | 445160 | B. WIN | ۱G_ | | 08/0 | 2/2010 |
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| K 051 | This STANDARD Based on observat facility failed to mai The findings includ Observation of the during the fire drill or revealed the strobe National Fire Prote 5.4.1.7.3 This findings was a Administrator and of Maintenance at the NFPA 101 LIFE SA A fire alarm system installed, tested, ar with NFPA 70 Natio 72. The system has | is not met as evidenced by: ion, it was determined the intain the alarm system. ed: 100, 200, 300, 400 corridors on 8/2/10 at 10:12 AM, e lights were not synchronized. ction Association (NFPA). 72, acknowledge by the verified by the Director of e exit conference on 8/2/10. AFETY CODE STANDARD in required for life safety is and maintained in accordance onal Electrical Code and NFPA is an approved maintenance in complying with applicable | K | 051 | It is the intention of the facithat a fire alarm system with approved components, devior equipment is installed NF72, National Fire Alarm Coto provide effective warning fire in any part of the building. 1. International Fire, contract facility vendor for our fire alarm system evaluated the strobe light capacity and for it not to be synchronized as reported. 2. Maintenance Supervisor at Assistant audited remainder building to determine compliance with synchronization of strobe lights. 3. Maintenance Supervisor was update the vendor contract International Fire to include annual testing of the strobe synchronization during the activation of the fire alarm. During monthly scheduled drills, maintenance departmentally will observe for the correct synchronization of the strolights. By 9/6/10, the first monthly check of the lights begin and on-going each metallights. | ted ind r of on will with e the lights fire nent be will onth. | 8-9-10 8-5-10 9-15-10 |
| | į | | | | 4. Maintenance Supervisor v | | |

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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | K 051 | l, cont'd | | | responsible to report month findings of the synchronizat of the strobe lights and the rof the annual audit by the findings of the annual audit by the finding wendor, when appropriate CQI/QA & A Committed meeting. The CQI/QA & A Committed consists of: Director of Nurse a physician and at least 3 of facility staff. The Maintena Supervisor is a permanent most the CQI/QA & A Committed Administrator will be respond to assure that a monthly report | tion report re riate to re ee ses, her nce nember ttee. nsible ort will & A le the of the n. The re will ake ly. This he and if | 8/26/10 | |

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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER D REHABILITATION SUMMARY STA | | ID | 20 | EET ADDRESS, CITY, STATE, ZIP CODE 00 MAYFIELD DRIVE MYRNA, TN 37167 PROVIDER'S PLAN OF CORREC | TION | (X5) |
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| K 052 | Based on observati facility failed to mai The findings include Observation of the 10:15 AM, revealed with a cart. Nationa (NFPA). 72, 2-8.2.1 | s not met as evidenced by: on, it was determined the ntain the alarm system. ed: faundry room on 8/2/10 at I the pull station was blocked I Fire Protection Association cknowledge by the | K | 052 | | or | 8/2/10 |
| K 054 SS=D | Maintenance at the NFPA 101 LIFE SA All required smoke activating door hold maintained, inspect with the manufacture. This STANDARD is Based on observatifacility failed to main the findings included the observation of the entrance door on 8. | rerified by the Director of exit conference on 8/2/10. FETY CODE STANDARD detectors, including those lopen devices, are approved, and tested in accordance rer's specifications. 9.6.1.3 s not met as evidenced by: on, it was determined the intain the smoke detectors. ed: corridor by the dining room (2/10 at 9:35 AM, revealed the in the direct path of the air | | | 3. Maintenance Department, which consists of the Super and Assistant will begin a monthly audit of the accessi of all the pull stations in the facility. As of 8/2/10, the fi audit was completed with no discrepancies. The on-going will occur each month as pathe monthly preventive main program. Department Managers are as focus compliance rounds du weekdays and monitoring for blocking of pull stations will included in the rounds. | bility rst o g audit rt of ntenance ssigned ring the or the | 9/8/10 |

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| | | | | | Department Managers will be serviced by the Maintenance Supervisor and Administrator including the monitoring of the blocking of pull stations. Findings of the compliance rounds will be submitted to the discipline responsible for correction. The manager is response for correction and for docume | for ne ne ne onsible | 9/7/10 |
| ! | K 052, cont'd | | | | to resolution to the original conpliance round report. The find from the compliance report with discussed dring our weekday? Morning Meeting with the Dement Managers. 4. The Maintenance Supervisor measure the effectiveness of compliance with preventing the blocking of pull station access. | dings ill be 9am epart- will the he | 9/8/10 |
| | | | | | through the monthly preventi maintenance program. The p will require a monthly audit of pull stations for compliance. The Maintenance Supervisor accountable to report his mon findings of his audit to the COA Committee. The CQI/QA & A Committee sists of: Director of Nurses, a physician and at least 3 other members of the facility staff. | or all will be othly QI/QA & | 9/13/10 8/26/10 |

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Facility ID: TN7503

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | MULTIPLE CONSTRUCTION IILDING | | (X3) DATE SURVEY COMPLETED | |
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| | K 05 | 2, cont'd | | Maintenance Supervimanent member of the Administrator will be to assure that a month presented to the CQI mittee and will include and any necessary activities with reconnecessary. Administrator will as follow-up will be proceed to the CQI/QA & A Committee and/or the Committee action plan has been pleted. | his committee. e responsible thly report will be t/QA & A Com- de audit findings ction plan. Plans the CQI/QA & A commendations as essure that any covided at each each each esserting un- ance is achieved the feels that the | 8/26/10 | |

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Event ID: 7KCN11

Facility ID: TN7503

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| STATEMEN" | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
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| K 064 | Maintenance at the | 1 | K | 054 | It is the intent of t his facilithat all required smoke detectors are approved and maintained in accordance with the manufacturers specifications, 9.6.1.3 | ty | | |
| SS=E | health care occupa | uishers are provided in all incies in accordance with , NFPA 10 | | | 1. Maintenance Supervisor contract with outside vend to relocate the smoke dete to allow for sufficient distant to deter detector from direpath of air return vent. | or ctor ance | 9-13-10 | |
| | Based on observat facility failed to ma The findings includ | | | | 2. Mainenance Department of ducted an audit of entire fa to assess for the proper plament of smoke detectors in relation to the location of the air return vent. | cility ce- | 8/3/10 | |
| | room and the outsi 8/2/10 at 10:10 AM extinguishers were | area outside of the laundry de hot water heater room on l, revealed the fire blocked with equipment. ction Association (NFPA). | | | 3. Preventive Maintenance p gram requires the monthly of all smoke detectors for p location compliance. | audit proper | 9/13/1 | |
| K 147 | Administrator and Maintenance at the | re acknowledge by the reified by the Director of exit conference on 8/2/10. AFETY CODE STANDARD | 34 0 | | The audit findings has been to the preventive maintenant 4. The Maintenance Supervireport the findings of his au | nce log. sor will idit to | 9/1/10 | |
| SS=E | | d equipment is in accordance tional Electrical Code. 9.1.2 | | | the monthly CQI/QA & A mittee. Any audit findings show a negative outcome o negative findings will requiplan of action to address the | that r any ire a | | |
| | | is not met as evidenced by: ion, it was determined the | | | issues. This plan of action | | | |

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Facility ID: TN7503

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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | K 054, | , cont'd | | | also be presented to the CQI/QA Committee and will continue to be presented from month to month to this committee with a follow-up interventions until stime that the plan of action has successfully resolved or at what time the Committee feels that compliance has occurred. The CQI/QA & A Committee consists of: Director of Nurse, physician and at least 3 other to members from the facility staff. The Maintenance Supervisor is permanent member of this contract The Administrator will be responsible to assure that a monthly report presented to the CQI/QA & A mittee and will include audit follow-up will be provided at a CQI/QA & A Committee meet until such time compliance is a and/or the Committee feels the action plan has been successful pleted. | the uch so been ich a earn f. is a mmittee. ponsible t will be Comindings ion. any each ting achieved at the | 8/26/10 |

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Facility ID: TN7503

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DEPARTMENT OF HEALTH AND HUTTON SERVICES CENTERS FOR MEDICARE & MEDIC. D SERVICES

PRINTED: 08/06/2010 FORM APPROVED OMB NO. 0938-0391

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IULTIPLE CONSTRUCTION | (X3) DATE S COMPL | |
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| | | | K 06 | It is the intent of that portable fir are provided in 9.7.4.1 19.3.5.6 I. Maintenance moved equipmed blocking fire equipmed blocking fire equipmed blocking fire equipmed blocking fire example and accessible for the second wide audit of fire to verify that not and accessible for a second to the second fire extinguisher inclusion of this monthly prevent program. Department Manassigned routine rounds during the assessing for acceptance with the rounds. Department Manaserviced by the 1 | of the facility re extinguishers accordance with 6, NFPA 10 Supervisor re- nent that was extinguisher andry room and extroom. Supervisor and acted a facility- re extinguishers one were blocked for use. expartment, which supervisor and the egin a monthly essibility of all rest through the audit in the cive maintenance magers are compliance e weekdays and essibility of fire and the cive maintenance libe included in magers will be in- | 8/2/10 8/2/10 9/13/10 |
| | | | | including the mo | nitoring of the | |

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Event ID: 7KCN11

Facility ID: TN7503

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K 064

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | (X2) MULTIPLE CONSTRUCTION | | | URVEY ETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | K 064 | , cont'd | | | accessibility of fire extinguis for use. Department Managers consist Asst. Director of Nurses, Rist Manager, MDS Nurses (2), Staff Manager, MDS Nurses (2), Staff Development Nurse, Staff Development Nurse, RN, Housekeep Supervisor, dietary Manager, Treatment LPN, Maintenance Supervisor, Director of Nurse Bookkeeper, Rehab Director Administrator. Findings of the compliance rewill be submitted to the discit responsible for correction. To manager is responsible for an accorrective action and for the documentation to the original compliance rounds report where resolved. Compliance Round findings of discussed during our weekday Morning Meeting with the Dement Managers. 4. The Maintenance Supervisor measure the effectiveness of a compliance with keeping all free extinguishers accessible through the program. The program will read monthly preventive maintena program. The program will read monthly audit of all facility | st of: sk Social rse, ant, lop- ing ees, and ounds pline The ny I nen will be y 9am epart- or will the fire ugh the nce require | 9/7/10 |

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Facility ID: TN7503

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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU | DING | (X3) DATE SURVEY COMPLETED | |
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| | | 445160 | B. WIN | | 08/0 | 4/2010 |
| | ROVIDER OR SUPPLIER | CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE SMYRNA, TN 37167 | 3010 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
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| | K 064 | , cont'd | | extinguishers for compliance The Maintenance Supervisor accountable to report his more findings of his audit to the Co A Committee. The CQI/QA & A Committee sists of: Director of Nurses, a physician and at least 3 other bers of the facility staff. The Maintenance Supervisor permanent member of this co mittee. Administrator will be respons to assure that a monthly repor be presented to the CQI/QA of Committee and will include a findings and any necessary ac plan. Plans will be reviewed | will be nthly QI/QA & e con- is a mem- sible rt will & A audit ction | 9/13/10 |
| | | | | CQI/QA & A Committee wit recommendations as necessar Administrator will assure that follow-up will be provided at CQI/QA & A Committee me until such time compliance is achieved and/or the Committee the action plan has been successive. | h t any each eting ee feels | 8/26/10 8/26/10 |
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Event ID:7KCN11

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PRINTED: 08/05/2010 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | | PLE CONSTRUCTION O1 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER D REHABILITATION | CENTER | 20 | EET ADDRESS, CITY, STATE, ZIP CODE 00 MAYFIELD DRIVE MYRNA, TN 37167 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| K 147 | The findings included Observation of the Resident room 101 revealed broken light protection Associated Observation of the machine room on 8 light covers were in Observation of the room on 8/2/10 at electrical outlets not ground fault circuited 210-8(a)(5) Observation of the 10:20 AM, revealed were ground fault on NFPA 70, 517-20 These findings were Administrator and | nply with the electrical codes. | K 147 | It is the intent of the facilia that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2. 1. Broken light cover in 16 shower room and resident 101 were replaced with copliant light covers. Light covers placed on light beauty shop and dish made room in dietary. GFCI's were installed to electrical outlets located sink in the break room are south medication room. Electrical outlets in the karea that were not GFCI corrected to reflect all area GFCI. 2. Maintenance Supervisor Assistant conducted a face wide audit of all outlets light fixtures were author proper lighting and procovering. 3. Maintenance Supervisor audit compliance with Gian monthly basis through the preventive maintenance proversive maintenance proper lighting and proventive maintenance proventive proventive proventive proventive proventive proventive pr | ce OO hall It Rm. com- ghts in chine the next to nd the itchen were e now r and cility- ocated CI. dited coper r will FCI's on the | 8/2/10 8/2/10 8/2/10 8/2/10 8/3/10 9/13/10 |

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Event ID:7KCN21

Facility ID: TN7503

If continuation sheet Page 5 of 5

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|-------------------|---|--|---|----------------------------|--|
| | | | A. BUILDIN | | G | ļ | ļ | |
| | 445160 8. WING | | | 08/04/2010 | | | | |
| NAME OF PROVIDER OR SUPPLIER MAYFIELD REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE SMYRNA, TN 37167 | | | | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLETION DATE | |
| | | | | | included on the monthly pre- ventive maintenance program Department Managers are ass routine compliance rounds du | signed oring the | 9/13/10 | |
| | | | | | weekdays and assessing for p light covering will be include the compliance rounds. Department Managers will be services by the Maintenance | mpliance rounds. tment Managers will be in- | | |
| | K 147, cont'd | | | | Supervisor and Administrator including the monitoring of the appropriate light coverings. Findings of the compliance rowill be submitted to the discipant responsible for correction. The manager is responsible for an corrective action and for the documentation to the original compliance rounds report where resolved. Compliance Round findings who be discussed during our week 9am Morning Meeting with the Department Managers. Department Managers. Department Managers consist Asst. Director of Nurses, Risk Manager, MDS Nurses (2), Services (2), Restorative Nurse Activity Director and Assistan Care Plan Nurse, Staff Development Nurse, RN, Housekeeping Supervisor, Dietary Manager, | ne ounds pline he y en will day he t of: c ocial se, nt, op- ng | 9/7/10 | |

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Event ID: 7KCN11

Facility ID: TN7503

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | | (X3) DATE SU COMPLE | | |
|--|---|--|-------------------|---|---|--|-----------------------------|--|
| | 44 5160 | | B. Wil | B. WING | | 08/04/2010 | | |
| NAME OF PROVIDER OR SUPPLIER MAYFIELD REHABILITATION CENTER | | | • | STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE SMYRNA, TN 37167 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREF TAG | | | JLD BE | (X5) COMPLETION DATE | |
| | K 14' | 7, cont'd | | | Supervisor, Director of Nurse Bookkeeper, Rehab Director of Administrator. Findings of the compliance rowill be submitted to the discipresponsible for correction. The manager is responsible for any corrective action and for the documentation to the original compliance rounds report who resolved. Compliance Round findings with discussed during our weekday Morning Meeting with the Dement Managers. 4. The Maintenance Supervisor measure the effectiveness of opliance through the monthly and the findings of the audit will presented by the Maintenance Supervisor at the monthly COQA & A Committee meeting. Trends with non-compliance wereviewed by the Committee a Maintenance Supervisor will sponsible for presenting an act to address these trends/issues compliance. Action plans will require mor follow-up until resolved and/ocommittee feels compliance achieved. The CQI/QA & A Committee | and ounds oline he y en will be y 9am epart- r will com- audit be e QI/ Any will be nd the be re- ction plan of non- nthly or the has been | 9/8/10 9/8/10 8/26/10 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED 08/04/2010 | |
|---|--|---|---------|---|---|---|----------------------------|
| | 445160 | | B. WING | | <u></u> | | |
| | ROVIDER OR SUPPLIER D REHABILITATION | CENTER | • | 2 | REET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE SMYRNA, TN 37167 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | IX | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE) | ULD BE | (XS) COMPLETION DATE |
| | K 14 | 7, cont'd | | | of: Director of Nurses, a phys at least 3 other members of the staff. The Maintenance Supervisor permanent member of this Constant Administrator will be responsed assure that a monthly report we presented to the CQI/QA & A mittee and will include audit and any necessary action plan will be reviewed by the Community with recommendations as necessary and assure that follow-up will be provided at monthly CQI/QA & A Community CQI/QA & A Community CQI/QA & A Community CQI/QA & COMMUNITY | is a similar is a | 8/26/10 |